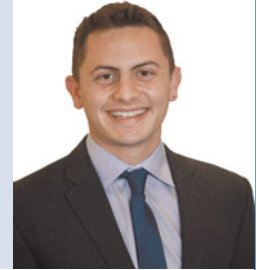


## Editorial

## Envisioning a future for transgender and gender-diverse people beyond the DSM

Jacob E. Perlson, Oakland C. Walters and Alex S. Keuroghlian



## Summary

This editorial describes current considerations regarding psychiatric diagnoses for transgender and gender-diverse (TGD) people. In addition to offering an assessment of the limitations in current diagnostic standards, the authors articulate a vision for psychiatric practice marked by renewed commitment to an affirmative framework that reduces stigma.

## Keywords

Nosology; sexual and gender identity disorders; stigma and discrimination; history of psychiatry; social functioning.

## Copyright and usage

© The Author(s), 2020. Published by Cambridge University Press on behalf of the Royal College of Psychiatrists.

**Jacob Perlson** (pictured), MPH, is an MD candidate at the Geisel School of Medicine at Dartmouth College in Lebanon, New Hampshire, and a researcher at The Fenway Institute in Boston, Massachusetts. **Oakland Walters**, MD, is a resident psychiatrist at Dartmouth-Hitchcock Medical Center in Lebanon, New Hampshire. **Alex Keuroghlian**, MD, MPH, is Director of the National LGBT Health Education Center at The Fenway Institute, Director of Massachusetts General Hospital Psychiatry Gender Identity Program and Associate Professor of Psychiatry at Harvard Medical School in Boston, Massachusetts, USA.

Forty years after the first diagnosis related to gender identity was formalised in the DSM, considerable progress has been made in the movement towards greater acceptance and visibility for transgender and gender-diverse (TGD) people.<sup>1</sup> Momentum is evident both among the general public and in the field of psychiatry, where major professional organisations have condemned the myriad forms of discrimination that TGD people may face. Even so, there remain formidable challenges in supporting the mental health of TGD communities. Among these are the need to resist harmful practices such as gender identity conversion efforts, to affirm gender diversity as normal variation of human expression and to remain vigilant about the risk of psychiatry as a field perpetuating stigma towards TGD communities. This last point is particularly salient in the discourse on continued inclusion of diagnoses related to gender identity in the DSM. While the change from a diagnosis of ‘gender identity disorder’ to one of ‘gender dysphoria’ in DSM-5 represented psychiatry’s increasingly affirming stance towards TGD populations, complete depathologisation – uncoupling gender diversity from the stigma of diagnostic classification and clinical practice suggesting illness or disorder – remains a necessary and worthy goal for our field to work towards.<sup>2</sup>

### What really drives the requirement for psychiatric assessment?

Psychiatry maintains a fraught relationship with TGD communities.<sup>3</sup> TGD advocates have noted that emphasis on psychological assessment in the current *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People* (SOC7), published by the World Professional Association for Transgender Health,<sup>4</sup> may lead some to erroneously interpret that documentation of a psychiatric condition must precede routine

gender-affirming medical care. In reality, the SOC7 highlight a complementary ‘informed consent model’ that empowers primary care clinicians to facilitate conversations about initiating gender-affirming care with TGD patients. Clinicians in primary care settings can screen for psychological distress and social concerns, and then refer or consult as necessary. In the case of gender-affirming surgical care, for which prior psychiatric evaluation is the norm, the goal of psychiatric evaluation is not to establish that patients are sufficiently dysphoric to merit surgical intervention. Rather, these evaluations aim to ensure that patients are both connected to services that emphasise wellness during a potentially stressful period of personal change and are engaged in care for possible psychiatric conditions that may affect, but not preclude, gender-affirming surgery. It is therefore confounding that a psychiatric diagnosis is nevertheless required by insurers and other providers when reimbursing or delivering gender-affirming care.

Wholesale removal of gender dysphoria from DSM-5 is unlikely to completely resolve these tensions and could have the unintended consequence of compromising access to critical psychiatric and medical services; third-party payers often require diagnosis codes for reimbursement, and thus a formal diagnosis may protect against coverage denials. These diagnoses have also been incorporated into a legal framework for establishing the medical necessity of various gender-affirming therapies.<sup>5</sup> It remains to be seen whether alternative solutions, such as non-diagnosis codes in the ICD (Z-codes in ICD-10 or Q-codes in ICD-11) that specify ‘factors influencing health status’, will allow for consistent reimbursement by third-party payers.<sup>5</sup> Another approach may involve seeking reimbursement for specific services without attaching a diagnosis *per se*. For example, ‘psychiatric evaluation preceding gender-affirming surgical intervention’ succinctly describes the rationale for and focus of these consultations without an assumption of psychopathology.

### Questions that must be asked

Until then, we must ask how psychiatry can be responsive to concerns within TGD communities about the ongoing existence of gender dysphoria and related diagnoses in DSM-5. For example, how can we ensure that TGD people who do not endorse gender-related dysphoria still receive affirming care? Can we understand experiences of gender diversity without an assumption of distress or pathology? What is the value in assigning a diagnosis to a child with no

immediate medical needs, when description of a specific service code (e.g. 'gender-affirming counselling in childhood') may suffice? Why is a specific diagnosis needed for a child struggling with questions related to their gender identity, but not their sexual orientation?

The answers to these questions will not be resolved with minor semantic changes or criterion adjustments from one edition of the DSM to the next; it is clear that the paradigm of diagnose-and-treat is not sufficient to fully support the health, and affirm the dignity, of TGD communities. The minority stress model helps explain how societal stigma associated with gender minority status may become embodied and manifest in adverse mental and physical health outcomes.<sup>6</sup> Given the unique stigma associated with receiving a psychiatric diagnosis, it is possible that such a label may do more harm than good.




### Challenging the centrality of the DSM in understanding TGD people

The inclusion, revision and subsequent removal of homosexuality in successive editions of the DSM is illustrative of how our conceptions of gender identity may also evolve. A full history of homosexuality in the DSM is beyond the scope of this article and has been previously described.<sup>3</sup> The arc of this progression involved advocacy within and beyond psychiatry, to transform societal perception of non-heterosexual sexual orientations from pathology to healthy human diversity. Claims of 'ego-dystonic' homosexuality were not found to be empirically substantiated, the sources of internal distress were understood to be societal homophobia rather than inherent disorder, and the discourse regarding the validity of diverse sexual orientations largely resolved within psychiatry, and medicine on the whole. Sexual minority people with psychiatric concerns such as major depressive disorder and substance use disorders are treated for these disorders without need for a sexual minority-specific diagnostic code. There is no imperative to establish a diagnosis of 'sexual dysphoria' for reimbursement even if the concept may be pertinent or worthy of exploration clinically. We are not suggesting abandonment of the concept of gender dysphoria, but rather advocating a self-critical psychiatry in which the centrality of the DSM in understanding TGD people is challenged.

Important differences exist in considerations related to DSM diagnoses for sexual versus gender minority people. For example, gender dysphoria and related diagnoses currently serve to increase access to lifesaving physical interventions for TGD people, ranging from gender-affirming hormone therapies to surgeries, interventions that have no analogy with sexual minority people. Violence and discrimination against sexual minorities, and even more frequently against gender minorities, compel action by mental health clinicians through trauma-informed practice.<sup>2</sup> Codifying gender dysphoria in the DSM is one manifestation of this awareness that is specific to TGD people. However, it cannot be the entirety of our response, or an indication that diagnoses related to gender identity will always have a home in the DSM.

### Psychiatry's role in a future beyond the DSM

We acknowledge the key role of psychiatry, at its best, in promoting the wellness of TGD communities. We praise efforts to reduce stigma, maintain and expand access to care, conduct research that centres on the perspectives and priorities of TGD communities, and challenge us to imagine a future in which we support the autonomy and self-determination of TGD patients. Training clinicians to validate diverse gender identities without an assumption of pathology is part of this work. Tracking specific services and advocating for the expanded use of non-diagnosis codes that reflect social context is another step in the right direction. After all, the role of psychiatrists in supporting the mental health of TGD people is primarily in the clinical care, not the diagnoses, that we offer interdisciplinary teams and our patients.

**Jacob E. Perlson** , MPH, Department of Social and Behavioral Sciences, Harvard TH Chan School of Public Health, Boston, Massachusetts; Fenway Institute, Fenway Health, Boston, Massachusetts; and Geisel School of Medicine, Dartmouth College, Lebanon, New Hampshire, USA; **Oakland C. Walters** , MD, Department of Psychiatry, Dartmouth-Hitchcock Medical Center, Lebanon, New Hampshire, USA; **Alex S. Keuroghlian** , MD, MPH, Fenway Institute, Fenway Health, Boston, Massachusetts; and Department of Psychiatry, Harvard Medical School, Boston, Massachusetts; and Massachusetts General Hospital, Boston, Massachusetts, USA

**Correspondence:** Jacob E. Perlson. Email: [jperlson@hsph.harvard.edu](mailto:jperlson@hsph.harvard.edu)

First received 26 Apr 2020, accepted 29 May 2020

### Author contributions

J.P. and O.W. conceived the idea for the manuscript. J.P. conducted the primary literature review. J.P. and O.W. wrote the manuscript. A.K. supervised writing the manuscript and contributed content on mental health and gender identity.

### Declaration of interest

None.

ICMJE forms are in the supplementary material, available online at <https://doi.org/10.1192/bjp.2020.124>.

### References

- 1 Beek FT, Cohen-Kettenis PT, Kreukels BPC. Gender incongruence/gender dysphoria and its classification history. *Int Rev Psychiatry* 2016; **28**: 5–12.
- 2 Suess Schwend A, Winter S, Chiam Z, Smiley A, Cabral Grinspan M. Depathologising gender diversity in childhood in the process of ICD revision and reform. *Global Public Health* 2018; **13**: 1585–98.
- 3 Drescher J. Queer diagnoses revisited: the past and future of homosexuality and gender diagnoses in DSM and ICD. *Int Rev Psychiatry* 2015; **27**: 386–95.
- 4 Coleman E, Bockting W, Botzer M, Cohen-Kettenis P, DeCuypere G, Feldman, et al. *Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People (Version 7)*. World Professional Association for Transgender Health, 2012.
- 5 Drescher J. Controversies in gender diagnoses. *LGBT Health* 2014; **1**: 10–4.
- 6 Hatzenbuehler ML. How does sexual minority stigma 'get under the skin'? A psychological mediation framework. *Psychol Bull* 2009; **135**: 707–30.